TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
HOUSTON METRO ORTHO SPINE SURGERY CTR

Respondent Name
TRUMBULL INSURANCE CO

MFDR Tracking Number
M4-15-2858-01

Carrier's Austin Representative
Box Number 47

MFDR Date Received
MAY 4, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "I Prior to the patient's admission, the Hospital was provided with authorization number 1375135 for the lumbar laminectomy/discectomy. The Hospital performed the medically necessary surgery, but the bill was denied because the services were not allowable under Medicare's ASC guidelines. Sedgwick subsequently issued payment of $9,145.61, but the remaining balance remains unpaid."

Amount in Dispute: $53,254.39

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "This case concerns reimbursement for services provided by Houston Metro Ortho Spine SC for date of service 7/16/14. As the attached EOBs explain, Trumbull paid Houston Metro in accordance with the Texas Workers' Compensation Act and applicable Fee Guidelines."

Response Submitted by: Burns Anderson Jury & Brenner, L.L.P.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 16, 2014	Ambulatory Surgical Care Services for CPT Code 63030-LT and C1765	$53,254.39	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307, effective June 1, 2012, sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.402, effective August 31, 2008, sets out the reimbursement guidelines for ambulatory surgical care services The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 985-Service is not allowable under Medicare's ASC guidelines.
   - 243-The charge for this procedure was not paid since the value of this procedure is included/bundled within

the value of another procedure performed.

- OA-The amount adjusted us due to bundling or unbundling of services.
- 948-R04-Re-reviewed at providers request with additional information and documentation-Additional payment suggested.
- W3-Additional payment made on appeal/reconsideration.
- 947-Upheld no additional allowance has been recommended.

Issues

Is the requestor due additional reimbursement for services rendered on July 16, 2014?

Findings

1. 28 Texas Administrative Code §134.402(d) states, "For coding, billing, and reporting, of facility services covered in this rule, Texas workers' compensation system participants shall apply the Medicare payment policies in effect on the date a service is provided with any additions or exceptions specified in this section, including the following paragraphs. (1) Specific provisions contained in the Labor Code or the Texas Department of Insurance, Division of Workers' Compensation (Division) rules, including this chapter, shall take precedence over any conflicting provision adopted or utilized by the CMS in administering the Medicare program."

2. CPT code 63030 is defined as "Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc; 1 interspace, lumbar."

   The requestor appended modifier "LT-left side" to code 63030.

3. According to the explanation of benefits, the respondent initially denied reimbursement for CPT code 63030-LT based upon reason code "985." Upon reconsideration, the respondent paid $9,145.61 for the disputed service.

4. 28 Texas Administrative Code §134.402(f)(1)(A) states, "The reimbursement calculation used for establishing the MAR shall be the Medicare ASC reimbursement amount determined by applying the most recently adopted and effective Medicare Payment System Policies for Services Furnished in Ambulatory Surgical Centers and Outpatient Prospective Payment System reimbursement formula and factors as published annually in the *Federal Register*. Reimbursement shall be based on the fully implemented payment amount as in ADDENDUM AA, ASC COVERED SURGICAL PROCEDURES FOR CY 2008, published in the November 27, 2007 publication of the *Federal Register*, or its successor. The following minimal modifications apply: (1) Reimbursement for non-device intensive procedures shall be: (A) The Medicare ASC facility reimbursement amount multiplied by 235 percent."

   A review of Addendum AA, ASC Covered Surgical Procedures for CY 2014 finds that code 63030 is not listed; therefore, 28 Texas Administrative Code §134.402(i) applies.

5. 28 Texas Administrative Code §134.402(i) states, "If Medicare prohibits a service from being performed in an ASC setting, the insurance carrier, health care provider, and ASC may agree, on a voluntary basis, to an ASC setting as follows:
   (1) The agreement may occur before, or during, preauthorization.
   (2) A preauthorization request may be submitted for an ASC facility setting only if an agreement has already been reached and a copy of the signed agreement is filed as a part of the preauthorization request.
   (3) The agreement between the insurance carrier and the ASC must be in writing, in clearly stated terms, and include:
   (A) the reimbursement amount;
   (B) any other provisions of the agreement; and
   (C) names, titles and signatures of both parties with dates.
   (4) Copies of the agreement are to be kept by both parties. This agreement does not constitute a voluntary network established in accordance with Labor Code §413.011(d-1)."

   A review of the submitted documentation finds that the requestor did not submit any documentation that an agreement was reached prior or during preauthorization. The dispute packet did not contain a signed copy of an agreement, that identified the parties to the agreement, or the amount of reimbursement as required by 28 Texas Administrative Code §134.402(i). As a result, additional reimbursement is not recommended.

6. On the disputed date of service, the requestor also billed HCPCS code C1765. This code was denied payment by the respondent based upon reason code "243."

7. HCPCS code C1765 is defined as "Adhesion barrier."

8. Per Medicare Addendum BB, code C1765 has a payment indicator of “N1.”

9. Medicare Addendum DD1 defines payment indicator of “N1” as “Packaged service/item; no separate payment made.”

10. 28 Texas Administrative Code §134.402(d)(1) states in part, “Specific provisions contained in the Labor Code or the Texas Department of Insurance, Division of Workers' Compensation (Division) rules, including this chapter, shall take precedence over any conflicting provision adopted or utilized by the CMS in administering the Medicare program.”

11. 28 Texas Administrative Code §134.402(f)(1)(B)(i) and (ii) states, “The reimbursement calculation used for establishing the MAR shall be the Medicare ASC reimbursement amount determined by applying the most recently adopted and effective Medicare Payment System Policies for Services Furnished in Ambulatory Surgical Centers and Outpatient Prospective Payment System reimbursement formula and factors as published annually in the *Federal Register*. Reimbursement shall be based on the fully implemented payment amount as in ADDENDUM AA, ASC COVERED SURGICAL PROCEDURES FOR CY 2008, published in the November 27, 2007 publication of the *Federal Register*, or its successor. The following minimal modifications apply: (1) Reimbursement for non-device intensive procedures shall be: (B) if an ASC facility or surgical implant provider requests separate reimbursement for an implantable, reimbursement for the non-device intensive procedure shall be the sum of: (i) the lesser of the manufacturer's invoice amount or the net amount (exclusive of rebates and discounts) plus 10 percent or $1,000 per billed item add-on, whichever is less, but not to exceed $2,000 in add-on's per admission; and (ii) the Medicare ASC facility reimbursement amount multiplied by 153 percent.”

    The Division finds that even though Medicare does not allow separate reimbursement for code C1765, 28 Texas Administrative Code §134.402 does if requested.

    A review of the submitted medical bills, letter requesting reconsideration, and documentation finds that the requestor did not request separate reimbursement for the implantable prior to seeking medical fee dispute resolution. In addition, an invoice to support the cost of C1765 was not submitted. As a result, reimbursement is not recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		11/13/2015
Signature	Medical Fee Dispute Resolution Officer	Date
		11/13/2015
Signature	Medical Fee Dispute Resolution Manager	Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.